


2007 Leave Without Pay (LWOP) Continuation Coverage Election

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- List **only** eligible family members you wish to enroll.
- **We must receive your first payment before you can be enrolled.** (Make checks payable to the Washington State Treasurer.)
- Attach appropriate **dependent certification** forms if required (students age 20 through age 23, extended dependents, and dependents with disabilities.) Forms are available at www.pebb.hca.wa.gov.

Section 1: SUBSCRIBER INFORMATION				Date employer coverage ended _____	
Social security number _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last name _____	First name _____	Middle initial _____	
Address _____					Apt./unit number _____
City _____	State _____	ZIP Code _____	County of residence _____		
Date of birth (mm/dd/yyyy) _____	Work phone number (including area code) _____ ()		Home phone number (including area code) _____ ()		
The medical plan marked with an asterisk (*) in Section 4 assigns a physician or clinic code to its providers and requires you to choose a primary care provider. Contact your plan for code.				Physician or clinic code 	
Are you part-time faculty? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select coverage you wish to continue: <input type="checkbox"/> Medical/Dental <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only <input type="checkbox"/> Life insurance <input type="checkbox"/> Long-term disability (only if on educational leave)					
<input type="checkbox"/> Cancel all coverage Reason _____ Date of qualifying event _____					
Are you covered by another group medical or dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____					
*Note: If you are enrolled in Medicare Part(s) A and/or B, attach a copy of your Medicare card(s) along with this form.					

Section 2: SPOUSE OR SAME-SEX DOMESTIC PARTNER INFORMATION <i>List only eligible family members.</i>				
Social security number _____	Date of marriage (mm/dd/yyyy) _____	Physician or clinic code _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Last name _____	First name _____	Middle initial _____	Date of birth (mm/dd/yyyy) _____	
Address (if different from subscriber) _____		City _____	State _____	ZIP Code _____
Select coverage you wish to continue: <input type="checkbox"/> Medical/Dental <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only				
<input type="checkbox"/> Cancel all coverage Reason _____ Date of qualifying event _____				
Are you covered by another group medical or dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____				
*Note: If you are enrolled in Medicare Part(s) A and/or B, attach a copy of your Medicare card(s) along with this form.				

Qualifying event (please check one)		
<input type="checkbox"/> Applying for disability retirement	<input type="checkbox"/> Reversion employee	<input type="checkbox"/> Approved educational leave
<input type="checkbox"/> Reduction in force (RIF)	<input type="checkbox"/> Approved leave without pay (LWOP)	<input type="checkbox"/> Seasonal employment
<input type="checkbox"/> Part-time faculty reduction in hours	<input type="checkbox"/> Workers' compensation	<input type="checkbox"/> Other _____
<input type="checkbox"/> Military leave (provide date called to duty _____)		



Visit our Web site at www.pebb.hca.wa.gov

Section 3: FAMILY MEMBER INFORMATION (Such as child, grandchild, etc.) <i>Use additional forms for more members. List only eligible family members you wish to enroll.</i>				
Relationship to subscriber	Social security number	Physician or clinic code	<input type="checkbox"/> Disabled? <input type="checkbox"/> Student? Sex <input type="checkbox"/> M <input type="checkbox"/> F <small>Check only if age 20 or older.</small>	
Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)	
Address (if different from subscriber)		City	State ZIP Code	
Select coverage you wish to continue: <input type="checkbox"/> Medical/Dental <input type="checkbox"/> Medical only <input type="checkbox"/> Dental only <input type="checkbox"/> Cancel all coverage Reason _____ Date of qualifying event _____				
Are you covered by another group medical or dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective date _____				
*Note: If you are enrolled in Medicare Part(s) A and/or B, attach a copy of your Medicare card(s) along with this form.				

Section 4: MEDICAL PLAN SELECTION (Check only one.)	Section 5: DENTAL PLAN SELECTION (Check only one.)
<div style="display: flex;"> <div style="flex: 1;"> <input type="checkbox"/> Community Health Plan Classic <input type="checkbox"/> Group Health Classic <input type="checkbox"/> Group Health Value <input type="checkbox"/> Kaiser Permanente Classic <input type="checkbox"/> Kaiser Permanente Value <input type="checkbox"/> Regence Classic* <input type="checkbox"/> Uniform Medical Plan </div> <div style="flex: 1; border: 1px solid black; padding: 5px; margin-left: 10px;"> <i>*This plan requires the physician or clinic code of your selected primary care provider. You may find the code in the provider directory on our Web site or by calling the plan.</i> </div> </div>	Preferred Provider Organization <input type="checkbox"/> Uniform Dental Plan (Group #3000) (may receive services from any provider) Managed Care Plans <input type="checkbox"/> DeltaCare (Group #3100) Dentist name _____ (must receive services from DeltaCare provider) <input type="checkbox"/> Regence BlueShield Columbia Dental Plan Clinic location _____ (must receive services from Willamette Dental Group provider) Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

Section 6: LIFE INSURANCE	Section 7: LONG-TERM DISABILITY																		
<table style="width: 100%;"> <tr> <th style="text-align: left;">Current Enrollment with Agency</th> <th style="text-align: left;">Coverage Amount</th> </tr> <tr> <td><input checked="" type="checkbox"/> Basic Part A (\$4.30/month)</td> <td>\$25,000</td> </tr> <tr> <td><input type="checkbox"/> Part B – Dependent/Children</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Part B – Spouse</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Part B – Supplemental Spouse</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Part C</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Part D</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Part E with Dependents</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Part E without Dependents</td> <td>_____</td> </tr> </table> <p>Desired Enrollment while Self-Paying</p> <p><input type="checkbox"/> I wish to maintain the same coverage I had as an active employee. _____ (initials)</p> <p><input type="checkbox"/> I do not wish to continue the life coverage while eligible for self-pay; I understand that I must reapply and submit evidence of insurability to reinstate optional life insurance when I return to work. _____ (initials)</p>	Current Enrollment with Agency	Coverage Amount	<input checked="" type="checkbox"/> Basic Part A (\$4.30/month)	\$25,000	<input type="checkbox"/> Part B – Dependent/Children		<input type="checkbox"/> Part B – Spouse		<input type="checkbox"/> Part B – Supplemental Spouse	_____	<input type="checkbox"/> Part C	_____	<input type="checkbox"/> Part D	_____	<input type="checkbox"/> Part E with Dependents	_____	<input type="checkbox"/> Part E without Dependents	_____	<p style="text-align: center;">This section applies ONLY to employees on educational leave.</p> <p>Current Enrollment with Agency</p> <p><input checked="" type="checkbox"/> Basic (\$2.45/month)</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> 30–Day <input type="checkbox"/> 60–Day <input type="checkbox"/> 90–Day </div> <div> <input type="checkbox"/> 120–Day <input type="checkbox"/> 180–Day <input type="checkbox"/> 240–Day </div> <div> <input type="checkbox"/> 300–Day <input type="checkbox"/> 360–Day </div> </div> <p>Desired Enrollment while Self-Paying</p> <p><input type="checkbox"/> I wish to maintain the same coverage I had as an active employee. _____ (initials)</p> <p><input type="checkbox"/> I do not wish to maintain the same coverage I had as an active employee. _____ (initials)</p>
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<input type="checkbox"/> Part E without Dependents	_____																		

Section 8: SIGNATURE (Required)
<p>Insurance coverage is determined through verification of eligibility by PEBB Benefit Services. I declare that to the best of my knowledge and belief my family members and I are eligible for the coverage requested. This form supersedes all forms and submissions I have previously made for coverage. A premium deposit does not guarantee coverage and will be returned if I am determined to be ineligible for coverage.</p> <p>Washington State law may require disclosure of any information I submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.</p> <p>Signature _____ Date _____</p>

Return to:
 Washington State Health Care Authority
 P.O. Box 42684
 Olympia, WA 98504-2684

If payment enclosed, return to:
 Washington State Health Care Authority
 P.O. Box 42695
 Olympia, WA 98504-2695